STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155131	A. BUILDING 00 B. WING	08/24/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MUNSTER MED-INN	7935 CALUMET AVENUE MUNSTER, IN46321

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F0000	This visit was for the Investigation of Complaint IN00094249. This visit resulted in a partially extended survey-Immediate Jeopardy. Complaint IN00094249- Substantiated, Federal/State deficiencies related to the allegations are cited at F 242, F 250, and F 323. Survey dates: August 22, 23, 2011 Extended date, August 24, 2011 Facility number: 000056 Provider number: 155131 AIM number: 100289450 Survey team: Janelyn Kulik, RN Census bed type: SNF: 15 SNF/NF: 177 Total: 192 Census payor type: Medicare: 30 Medicaid: 125 Other: 37 Total: 192 Sample: 6	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Supplemental sample: 3 These deficiencies also reflect State findings cited in accordance with 410 IAC 16.2. Quality review completed on August 26, 2011 by Bev Faulkner, RN			
F0242 SS=D	The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. Based on record review and interview, the facility failed to ensure a resident was given the opportunity to make choices related to restrictions from eating in the main dining room following the resident's elopement from the facility. This affected 1 of 6 residents reviewed in the sample of 6. (Resident #C). Findings included: The record for Resident #C was reviewed on 8/22/11 at 11:05 a.m. The resident's diagnoses included, but were not limited to, depression, dementia, and senile organic psychotic condition.	F0242	F-242 Submission of this response and Plan of Correction is not legal admission that a deficiency exists, or that a Statement of Deficiency was correctly cited. Submission of this response is not to be construed as an admission of any deficiency against the facility, the Administrator, or any employees who draft or may be discussed in this response and Plan of Correction. In direct response to the five questions listed on page two of Kim Rhoades, Director of Long Term Care, letter to this facility dated August 26, 2011, the facility offers the following: 1. What corrective action(s) will be accomplished for those residents found to have been affected by	08/25/2011

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	Review of nursing notes of 7/24/11, reportable incident report of 7/24/11, and social service note of 7/25/11, indicated Resident #C was found outside the facility and off the property on 7/24/11. The resident was observed at a shopping center adjacent to the facility by another family and the facility was notified. The resident was returned without incident or injury by facility staff. A nursing note, dated 7/25/11 at 9:00 a.m., indicated, the wanderguard remains to wheelchair. "Res (resident) states she is going to the dollar store next time its (sic) closer. Res (Resident) informed she is not to leave facility without staff or family." A nursing note, dated 7/25/11 at 12:15 p.m., indicated the resident was given her lunch tray by CNA. The resident was in her wheelchair and set up to eat prior to CNA leaving the room. At 12:45 p.m., the resident was at the nurse's station in her wheelchair stating she did not have lunch and that her lunch was in the bathroom. The CNA indicated the resident was set by her bed and window and the resident moved the tray. The resident was ordered another lunch tray. A social service note, dated 7/25/11, indicated resident was noted outside the		the deficient practice? Effective August 18, 2011, Resident C resumed Main Dining Room service. The facility is unable to retrospectively offer any further corrective action as it relates to Resident C's participation in Main Dining Room service. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? The facility is confident, with the implementation of our Chain of Supervision policy and procedure, that residents having the need for Wanderguard protection and who have the desire to attend the facility Main Dining Room will have the necessary supervision for meal service in the Main Dining Room. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The facility has implemented the Chain of Supervision policy and procedure which will allow residents with the need for Wanderguard protection to have the necessary supervision, if they desire for meal service in the Main Dining Room. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The facility is committed to meeting on a weekly basis for a minimum of 12	

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	facility and off property without assistance. Nursing went to get the resident and returned her to the facility with no injury. The resident indicated she wanted to go shopping and later indicated she wanted to go for a walk and was tired of being inside. A new order was received for a wanderguard. The resident later removed the wanderguard to wrist and a wanderguard to wheelchair was applied. Nursing has discussed situation and safety concerns with the resident and she stated she will leave when she wants to. In morning meeting, concerns were discussed and limiting resident's activity throughout the facility until resident safety can be better assessed. Social Service suggested a family meeting and family wanted to hold off at this time. The family was in agreement with facility attempts to keep resident safe with wanderguard, and limiting activities. Family indicated they visited yesterday and discussed concerns with the resident. The family indicated they will attempt to take the resident out on pass with family monthly as weather permits. Social service met with resident and discussed concerns. The resident had some confusion and noted difficulty with word finding. Social Service will continue to provide resident with supportive visits.		weeks and monthly thereafter (if deemed appropriate) to review and discuss all resident identified as having a risk for elopement and warrant the use of Wanderguard protection. During these meeting the multi-disciplinary team will review the current dining arrangement for each resident requiring Wanderguard protection to ensure that there has been no change in dining service. Should a change be noted, it will be necessary to provide documentation for the reason for the change. Regardless of the reason, Social Service will provide an initial well-check visit (additional visits may be necessary and will be documented as such in the Social Service section of the medical record) with the resident to ensure that there are no psycho-social impacts as a result of the change and will report any concerns to The Director of Social Service or Administration. 5. By what date will the systemic changes be completed? August 25, 2011	

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	A nursing note, dated 7/26/11 at 6:30 a.m., indicated, the resident was in her wheelchair in her room, alert, verbally responsive, skin was warm and dry. She was informed to stay on the unit for meals. The resident verbalized understanding. At 7:30 a.m., the resident was up in her wheelchair attempting to go down to the main dining room for breakfast. She'd stated to writer, "I can do as I please and do you really think that I don't know what I'm doing, I know exactly what I'm doing. I'll leave when I want to leave and (Roommate's name) is staying upstairs [sic] with me." It was explained to the resident why she was not able to go downstairs. Resident calmed down and stated, "Oh whatever and said alright." A social service note, dated 7/26/11, indicated the resident continues to exhibit periods of confusion and resident having difficulty with word finding and becomes frustrated in conversation at times. A new order was received to start Namenda (used to treat moderate to severe dementia). Social Service will continue to provide supportive visits with the resident and observe for changes in resident's mood/behavior. A nursing note, dated 7/28/11 at 3:10 p.m., indicated the resident was at the			

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	nurse's station wanting to leave the facility to go to the store. The resident was redirected by staff and Administrator was made aware. A nursing note, dated 8/7/11 at 4:30 p.m., indicated the resident indicated "she was going to leave (sic) facility when she went to activity. The writer spoke with res (resident) and informed her that she could not leave the facility without family or staff. Res (resident) got angry and went back to her room." A Psychiatry note, dated 8/11/11, indicated, "Pt (patient) seated in room. Discussed with her the incident when she left facility to go to Target. She said she didn't know she couldn't go stating 'I used to go to Target and the Dollar Store with my mother.' She said '5 minutes more [sic] they would have never known.' She stated 'I told them I would not do it again. They are being childish about it. It makes me want to do something else.' I explained she must now be restricted as a result of her own action. She was not accepting of this. She did laugh about it when I joked about it in order to lighten up the moment. She brought up her mother as if she were alive. Her memory was impaired. She now has a wanderguard on her wheelchair. She reportedly cut the one off her arm."			

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A nursing note, dated 8/15/11 at 7:45 a.m., indicated the resident was upset this morning and took her breakfast tray and put it on the floor in the middle of the hallway. At 7:50 a.m., the nurse spoke to the resident and had her pick up the tray out of the hallway. The resident picked the tray up and handed it to the nurse.

A social service note, dated 8/16/11, indicated social service was informed by nursing resident was upset and requesting wanderguard be removed. Resident had been refusing meals at times. The wanderguard placement was discussed with MDT and family. The family was informed of risks of removing wanderguard but explained facility desire to maintain resident's independence and dignity. The concerns of the resident refusing meals and the concern of the wanderguard having a negative affect on the resident were discussed. The resident indicated she will not leave the facility again unassisted and stated to social service today she wishes she would not have left. The family feels the resident will not attempt to leave the facility again and was remorseful about the situation. Family would like the wanderguard removed.

A nursing note, dated 8/18/11 at 2:40

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	p.m., indicated, MDT (Multidisciplinary Team) discussion today regarding wanderguard. The resident and family requested wanderguard be removed. The resident stated, "She will not leave the facility unattended, states she would like to go to dining room for meals and wants to attend activities. MDT feels that wanderguard should be removed at this time. Resident education done at this time. A social service note, dated 8/18/11, indicated MDT and Psychiatrist discussed with social service the removal of the wanderguard. Resident and family want the wanderguard removed. After further discussion, MDT feels that wanderguard should be removed at this time. The resident was educated on safety of not leaving the building unattended. The resident agrees and understands. Interview with the Administrator on 8/22/11 at 12:15 p.m., indicated the ground floor doors do not have a wanderguard alarm. The resident was not kept from the main dining room due to the wanderguard it was due to the staff monitoring the resident's behavior and her indicating she was still going to leave. It was then indicated with her stating she was going to leave and the doors not being activated by the wanderguard			

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	system it was felt in the best interest of the resident to keep her on the unit to monitor her behavior. The resident was allowed to come to the first floor supervised, but she was receiving her meals on the unit. Interview with the current Second Floor Unit Manager, the new Second Floor Unit Manager, Social Service #1, Administrator, and Assistant Administrator on 8/22/11 at 3:45 p.m., indicated the resident was having behaviors and not eating due to the wanderguards and being monitored on the unit. It was thought that in the best interest of the resident and to give the resident independence the wanderguard should be removed. It was then stressed that the resident wanted her independence and did not like staff being with her all of the time. This Federal tag relates to complaint IN00094249. 3.1-3(u)(3)			

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F0250 SS=E	The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on record review and interview, the facility failed to ensure social services were provided to maintain the highest practicable physical, mental, and psychosocial well-being of each resident for 3 of 4 residents who were at risk for elopement in a sample of 6 (Residents #C, #D, and #G) and 1 of 3 residents who were at risk for elopement in a supplemental sample of 3 (Resident #J) related to not completing annual elopement assessments per facility policy. The facility also failed to provide social service interventions for 1 of 6 sampled residents (Resident #C) after the resident was restricted to the unit after elopement from the facility and not allowed to eat in the main dining room. Findings include: 1. The record for Resident #C was reviewed on 8/22/11 at 11:05 a.m. The resident's diagnoses included, but were not limited to, depression, dementia, and senile organic psychotic condition. The resident was admitted to the facility on 6/22/09. A nursing note, dated 7/24/11 at 2:50	F0250	F-250 Submission of this response and Plan of Correction is not legal admission that a deficiency exists, or that a Statement of Deficiency was correctly cited. Submission of this response is not to be construed as an admission of any deficiency against the facility, the Administrator, or any employees who draft or may be discussed in this response and Plan of Correction. In direct response to the five questions listed on page two of Kim Rhoades, Director of Long Term Care, letter to this facility dated August 26, 2011, the facility offers the following: 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? As it relates to Residents C, D, G and J, updated Elopement Risk Assessments were completed on August 24, 2011 and are present on the medical record for each resident. In specific response to the corrective actions accomplished for Resident C, we offer the following: Resident C resumed meal service in the facility Main Dining Room as of August 18, 2011. Effective August 23, 2011, daily wellness visits with Resident C were initiated and will be completed for a period of two weeks to ensure	08/25/2011

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	p.m., indicated the nurse was "notified that res (resident) was outside of facility off of property by herself. This writer went to get res (resident). Res (resident) a/o (alert/oriented), skin w/d (warm/dry)." The resident's vital signs were temperature 98, pulse 78, respirations 20, and blood pressure 126/60. There was no acute distress noted. At 3:15 p.m., the resident's skin check was completed with no bruising noted. The resident indicated she was in no pain. At 3:17 p.m., the physician was notified. At 3:20 p.m., the resident's family was notified. At (no time indicated) a new order was received for a wanderguard. At 3:30 p.m., the wanderguard was applied to the resident's wrist and wheelchair as ordered. At 6:00 p.m., the resident had dinner in her room. At 6:10 p.m., the resident's family was visiting. At 7:00 p.m., the resident removed her wanderguard from her wrist. The resident was in her room in her wheelchair watching television. A nursing note, dated 7/25/11 at 9:00 a.m., indicated, the wanderguard remains to wheelchair. "Res (resident) states she is going to the Dollar Store next time its (sic) closer. Res (Resident) informed she is not to leave facility without staff or family." At 12:15 p.m., the resident was given her lunch tray by a CNA. The resident was in her wheelchair and set up		Resident C's psychosocial well-being is maintained. If there are no observed psychosocial concerns, weekly wellness visits will be completed for a minimum of two additional weeks. If there then appears to be no observable psycho-social concerns, routine Social Service visits will resume on an as needed basis. The results of the visits will be documented in the Social Service progress notes. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? As it relates to Resident C, D, G, and J, as of August 24, 2011, all facility residents were re-assessed for risk of elopement through the use of our Elopement Risk Assessment Tool (see attached). Multi-disciplinary discussions were completed for the individuals who were identified as having risk for elopement. The family and physician of all identified residents were contacted and necessary interventions were discussed and implemented for each individual resident effective August 25, 2011. For those residents identified as having a risk for elopement warranting the use of Wanderguard protection, a Chain of Supervision plan was implemented. As it relates to Resident C, the facility has confirmed with Dietary staff that there has been no change in our	

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	to eat prior to CNA leaving the room. At 12:45 p.m., the resident was at the nurse's station in wheelchair stating she did not have lunch and that her lunch was in the bathroom. The CNA indicated the resident was set by her bed and window and the resident moved the tray. The resident was ordered another lunch tray. A nursing note, dated 7/26/11 at 6:30 a.m., indicated, the resident was in her wheelchair in room, alert, verbally responsive, skin was warm and dry. She was informed to stay on the unit for meals. The resident verbalized understanding. At 7:30 a.m., the resident was up in her wheelchair attempting to go down to the main dining room for breakfast. Shed stated to writer, "I can do as I please and do you really think that I don't know what I'm doing, I know exactly what I'm doing. I'll leave when I want to leave and (Roommate's name) is staying upstairs (sic) with me." It was explained to the resident why she was not able to go downstairs. Resident calmed down and stated, "Oh whatever and said alright." A nursing note, dated 7/27/11 at 3:00 p.m., indicated, the resident's wanderguard to person was discontinued due to resident removal. At 11:30 a.m., the wanderguard to the resident's		Main Dining Room attendance as a result of any resident safety concerns on the part of the facility. Furthermore, the facility has reviewed all residents to ensure that there are no similar or other restrictions in place due to safety concerns. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? As it relates to Resident C, D, G, and J, the facility reviewed and revised the Elopement Risk Assessment policy and procedure. All facility Social Service staff were in-serviced regarding the revisions (see attached). As it relates to Resident C, the facility has implemented the Chain of Supervision policy and procedure which will allow residents with the need for Wanderguard protection to have the necessary supervision, if they desire to attend the Main Dining Room meal service. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? As it relates to Residents C, D, G and J, effective August 24, 2011, the facility completed a review of every residents chart and has verified the presence of an updated Elopement Risk Assessment and ensured compliance with our policy on Elopement Risk	

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	wheelchair was in place. A nursing note, dated 7/28/11 at 3:10 p.m., indicated the resident was at the nurse's station wanting to leave the facility to go to the store. The resident was redirected by staff and Administrator was made aware. A nursing note, dated 8/7/11 at 4:30 p.m., indicated the resident indicated "she was going to leave (sic) facility when she went to activity. The writer spoke with res (resident) and informed her that she could not leave the facility without family or staff. Res (resident) got angry and went back to her room." A nursing note, dated 8/15/11 at 7:45 a.m., indicated the resident was upset this morning and took her breakfast tray and put it on the floor in the middle of the hallway. At 7:50 a.m., the nurse spoke to the resident and had her pick up the tray out of the hallway. The resident picked the tray up and handed it to the nurse. A nursing note, dated 8/18/11 at 2:30 p.m., indicated the resident's wanderguard was discontinued and noted by social service. The resident's family was informed. At 2:40 p.m., MDT (Multidisciplinary Team) discussion today regarding wanderguard. The resident and		Assessments. A Quality Assurance Indicator has been created to review a random sample of 20 residents per floor per month (yielding 100 audits per quarter) to assess for the presence of a current Elopement Risk Assessment, and to evaluate the presence of and appropriateness of interventions and care planning based upon the findings of the Elopement Risk Assessment. The Director of Social Service will be responsible for completing this audit and will report findings to the Quality Assurance Committee on a quarterly basis for a minimum of one year. As it relates to Resident C, the facility is committed to meeting on a weekly basis for a minimum of 12 weeks and monthly thereafter (if deemed appropriate) to review and discuss all residents identified as having a risk for elopement and warrant the use of Wanderguard protection. We will review the current dining arrangement for each resident requiring Wanderguard protection to ensure that there has been no change in dining service. Should a change be noted, it will be necessary to provide the necessary documentation. Regardless of the reason, Social Service will provide an initial well-check visit (additional visits may be necessary and will be documented as such in the Social Service section of the medical	

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	155131	A. BUILDING 00 B. WING	08/24/2011

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	family requested wanderguard be removed. The resident stated, "She will not leave the facility unattended, states she would like to go to dining room for meals and wants to attend activities. MDT feels that wanderguard should be removed at this time. Resident Education done at this time. A Psychiatry note, dated 8/11/11, indicated, "Pt (patient) seated in room. Discussed with her the incident when she left facility to go to Target. She said she didn't know she couldn't go stating 'I used to go to Target and the Dollar Store with my mother.' She said '5 minutes more (sic) they would have never known.' She stated 'I told them I would not do it again. They are being childish about it. It makes me want to do something else.' I explained she must now be restricted as a result of her own action. She was not accepting of this. She did laugh about it when I joked about it in order to lighten up the moment. She brought up her mother as if she were alive. Her memory was impaired. She now has a wanderguard on her wheelchair. She reportedly cut the one off her arm." A quarterly Minimum Data Set Assessment, dated 7/21/11, indicated she was understood and she understands. She scored an eleven out of fifteen on the		record) with the resident to ensure that there are no psycho-social impacts as a result of the change and will report any concerns to The Director of Social Service or Administration. 5. By what date will the systemic changes be completed? August 25, 2011	

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	BIMS (Brief Interview for Mental Status) which indicated she was moderately impaired cognitively. The resident missed the correct year by one year, she was accurate to the month within five days, and she was able to recall one of the three words given at the beginning of the assessment with no cueing, she needed cueing for the second word, and could not recall the third word. A Mini-Mental State Examination (MMSE), dated 7/25/11, indicated a score of 18 out of 30 which would indicate the resident had moderate cognitive impairment. She answered correctly two of the following: year, season, date, day, and month. She answered correctly two of the following: state, country, town or city, hospital, and floor. She scored a two out of five when asked to spell the word "WORLD" backwards. When given three items to recall she could only recall one of the items. She could not copy a figure of intersecting pentagons. An Elopement Risk Assessment, dated 6/22/09, indicated this was an initial assessment and the resident was at risk and a wanderguard was in place. There were no other Elopement Risk Assessments in the resident's record.			

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	A care plan, initiated on 7/24/11, indicated a problem of exiting the facility alone. The approaches included, but were not limited to, reminding the resident it was dangerous to exit the building alone, wanderguard on bottom of wheelchair due to resident removing the wanderguard from her wrist, check wanderguard placement, and notify physician of any new orders. A social service note, dated 7/25/11, indicated resident was noted outside the facility and off property without assistance. Nursing went to get the resident and returned her to the facility with no injury. The resident indicated she wanted to go shopping and later indicated she wanted to go for a walk and was tired of being inside. A new order was received for a wanderguard. The resident later removed the wanderguard to wrist and wanderguard to wheelchair was applied. Nursing has discussed situation and safety concerns with the resident and she stated she will leave when she wants to. In morning meeting, concerns were discussed and limiting resident's activity throughout the facility until resident safety can be better assessed. Social Service suggested a family meeting and family wanted to hold off at this time. The family was in agreement with facility			

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	attempts to keep resident safe with wanderguard, and limiting activities. Family indicated they visited yesterday and discussed concerns with the resident. The family indicated they will attempt to take the resident out on pass with family monthly as weather permits. Social service met with resident and discussed concerns. There resident had some confusion and noted difficulty with word finding. A social service note, dated 7/26/11, indicated the resident continues to exhibit periods of confusion and resident having difficulty with word finding and becomes frustrated in conversation at times. A new order was received to start Namenda (used to treat moderate to severe dementia). A social service note, dated 8/16/11, indicated social service was informed by nursing resident was upset and requesting wanderguard be removed. Resident had been refusing meals at times. The wanderguard placement was discussed with MDT and family. The family was informed of risks of removing wanderguard but explained facility desire to maintain resident's independence and dignity. The concerns of the resident refusing meals and the concern of the wanderguard having a negative affect on the resident were discussed. The resident			

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	indicated she will not leave the facility again unassisted and stated to social service today she wishes she would not have left. The family feels the resident will not attempt to leave the facility again and was remorseful about the situation. Family would like the wanderguard removed. A social service note, dated 8/18/11, indicated MDT and Psychiatrist discussed with social service the removal of the wanderguard. Resident and family want the wanderguard removed. After further discussion MDT feels that wanderguard should be removed at this time. The resident was educated on safety of not leaving the building unattended. The resident agrees and understands. Interview with Social Service #1 on 8/22/11 at 12:00 p.m., indicated the most recent Elopement Risk Assessment for Resident #C was 6/22/09. She further indicated she was the staff member who would have completed the assessments and there were no other assessments. Interview with the Administrator on 8/22/11 at 12:15 p.m., indicated the ground floor doors do not have a wanderguard alarm. The resident was not kept from the main dining room due to the wanderguard it was due to the staff			

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	monitoring the resident's behavior and her indicating she was still going to leave. It was then indicated with her stating she was going to leave and the doors not being activated by the wanderguard system it was felt in the best interest of the resident to keep her on the unit to monitor her behavior. The resident was allowed to come to the first floor supervised but she was receiving her meals on the unit. Interview with the Director of Nursing and Administrator on 8/22/11 at 2:30 p.m., indicated she thought the resident's wanderguard from 6/22/09 was discontinued in January 2010. It was indicated the resident left the facility because she was angry her roommate would not be in the facility for the activity they had planned to do together and her roommate was going out with her family. It was further indicated the roommate's family will at times take Resident #C out with them when they go out. It was then indicated Resident #C had come along way from when she first came to the facility with her behaviors. Resident #C was also very territorial. It was also indicated when the resident would get on the elevator and her wanderguard would sound she would say, "That's me." Interview with the current Second Floor			

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	Unit Manager, the new Second Floor Unit Manager, Social Service #1, Administrator, and Assistant Administrator on 8/22/11 at 3:45 p.m., indicated the resident was a focused resident and she was to have periodical and interval checks being completed after her wanderguard was discontinued. It was further indicated that this meant checking on the resident during the day and multiple times at night. The resident was in activities all day so the checking was less frequent. The facility did not indicate who would do the checking on the resident or the frequency of the checks. It was also indicated the resident was having behaviors and not eating due to the wanderguards and being monitored on the unit. It was also indicated the resident not only took off her wanderguard, but was also trying to take the wanderguard off of her wheelchair. It was thought that in the best interest of the resident and to give the resident independence the wanderguard should be discontinued. There were no other interventions indicated after the wanderguard was discontinued. It was then stressed that the resident wanted her independence and did not like staff being with her all of the time. Interview with Social Service #1 on 8/24/11 at 9:45 a.m., indicated she spoke to the resident multiple times. The			

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resident would come to her office on the unit and talk to her, but she was not sure if she documented the visits. She indicated she does monthly documentation.

Interview with the Assistant Administrator and the Director of Nursing on 8/24/11 at 11:45 a.m., indicated they would see if there was any documentation of social service visits for the resident when she was restricted to the unit for meals.

During the exit interview on 8/24/11 at 2:00 p.m., there was no additional information provided related to social service visiting with the resident after she was restricted to her unit for meals.

2. The record for Resident #J was reviewed on 8/23/11 at 11:40 a.m. The resident's diagnoses included, but was not limited to, psychosis, advanced organic brain syndrome, and dementia with behavioral disturbances. The resident was admitted to the facility on 3/19/10.

A nursing note, dated 8/9/11 at 10:20 p.m., indicated the resident was wandering the unit and slight agitation was noted.

An Elopement Risk Assessment, dated 3/19/10, indicated the resident was at risk

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	for elopement and was residing on the secured unit and a wanderguard was ordered. There were no other Elopement Risk Assessments in the resident's record. A care plan, initiated on 12/7/10 and updated 3/1/11 and 5/3/11, indicated a problem of wandering. The resident wanders hallways and other resident's rooms. Resident can become exit seeking at times. The approaches included, but were not limited to, providing a safe wandering path, a wanderguard in place, observe whereabouts often, and encourage activity participation. Interview with the Assistant Administrator and the Director of Nursing on 8/23/11 at 2:00 p.m., indicated there were no other Elopement Risk Assessments completed other than when a resident was admitted to the facility. 3. The record for Resident #G was reviewed on 8/22/11 at 3:20 p.m. The resident's diagnoses included, but was not limited to, depression, cerebrovascular disease (stroke), unusual behaviors, and dementia. The resident was admitted to the facility on 7/22/09. The resident plan of care card indicated			

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	155131	A. BUILDING 00 B. WING	08/24/2011

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	the resident was to have a wanderguard on his chair and on his right arm. A care plan, initiated on 11/18/10 and updated on 2/23/11, 5/1/11, 7/27/11, and 8/9/11, indicated a problem of resident has a wanderguard in place due to a history of wandering. The approaches included, but were not limited to, Wanderguard in place at all times, encourage involvement in group activities, attempt to keep resident occupied, supportive visits from family to assist with shopping desires, and activities to continue to assist with shopping when weather permits. An Elopement Risk Assessment, dated 7/22/09, indicated this was an initial assessment and the resident was not at risk for elopement. There was no other Elopement Risk Assessments in the resident's record. Interview with the Assistant Administrator and the Director of Nursing on 8/23/11 at 2:00 p.m., indicated there were no other Elopement Risk Assessments completed other than when a resident was admitted to the facility. 4. The record for Resident #D was reviewed on 8/22/11 at 5:30 p.m. The			

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	155131	A. BUILDING 00 B. WING	08/24/2011

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	resident's diagnoses included, but were not limited to, depression, and dementia with behavioral disturbances. The resident was admitted to the facility on 11/6/09. Review of a Physician Order Statement for August of 2011, indicated a wanderguard was to be on the resident's wheelchair. Review of the resident's plan of care card did not indicate the resident had a wanderguard. Review of the resident's care plans did not show a care plan related to the resident wandering, at risk for elopement or for the resident to have a wanderguard. Review of an Elopement Risk Assessment, dated 11/6/09, indicated the resident was not at risk for elopement. There were no other Elopement Risk Assessments in the resident's record. Interview with Social Service Worker on the third floor on 8/24/11 at 9:15 a.m., indicated Elopement Risk Assessments were to be completed quarterly, annually and with change in condition. She indicated the assessments were implemented yesterday and there was no			

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	155131	A. BUILDING 00 B. WING	08/24/2011

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	other Elopement Risk Assessment for Resident #D after 11/06/09. 5. The Elopement Risk Assessment Policy was provided by the Administrator on 8/22/11 at 2:40 p.m. The Social Service Department was responsible for the procedure. The purpose: "To appropriately identify those at risk for elopement." The procedure included, but was not limited to, the following: "1.0 All new admissions will be assessed by Social Service during the completion of the Social History." "2.0 All other residents will be assessed by Social Service regardless of past "no" risk scores when changes in cognitive or behavioral status or when a new diagnosis of dementia is noted. 3.0 Social Service will generate, monitor, and update care plans detailing need for elopement response system. 4.0 All residents will be assessed annually." Interview with the Assistant Administrator and the Director of Nursing on 8/23/11 at 2:00 p.m., indicated there were no other Elopement Risk Assessments completed other than when a resident was admitted to the facility. When wanderguards were placed on residents it was done by Social Services and per policy Elopement Risk Assessments should have been done annually and were not. The facility was in			

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	the process of assessing all residents for elopement risk and the facility was updating their policy. There was no indication as to why social service were not completing the annual Elopement Risk Assessments. This Federal tag relates to complaint IN00094249. 3.1-34(a)			
F0323 SS=J	The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review and interview, the facility failed to ensure interventions were in place for supervision of a resident who had eloped, failed to assess the resident annually for risk of elopement and failed to assess prior to removing a wanderguard for 1 of 4 residents reviewed who were at risk of elopement in a sample of 6. (Resident #C)	F0323	F-323 Submission of this response and Plan of Correction is not legal admission that a deficiency exists, or that a Statement of Deficiency was correctly cited. Submission of this response is not to be construed as an admission of any deficiency against the facility, the Administrator, or any employees who draft or may be discussed in this response and Plan of Correction. In direct response to	08/25/2011

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	The immediate jeopardy began on 8/18/11 when no elopement assessment was completed and wanderguards were discontinued for a resident with a history of elopement. The Executive Director, Administrator, Assistant Administrator and Director of Nursing were notified of the immediate jeopardy at 4:30 p.m. on 8/22/11. The immediate jeopardy was not removed by the exit date of the survey. Findings include: Resident #C was observed on 8/22/11 at 11:02 a.m., in activities on the second floor playing BINGO. There was no wanderguard on her or on her wheelchair. On 8/22/11 at 12:15 p.m., Resident #C was observed on the ground floor in the main dining room eating lunch. There was no wanderguard observed on her or on her wheelchair. On 8/22/11 at 3:20 p.m., Resident #C was observed self propelling her wheelchair on the ground floor from activities to the elevator. She stopped her wheelchair behind another resident and was waiting with several other residents in the hallway. Staff were observed in the hallway with the residents. The record for Resident #C was reviewed		the five questions listed on page two of Kim Rhoades, Director of Long Term Care, letter to this facility dated August 26, 2011, the facility offers the following:1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? As it relates to Resident C, upon notification of the concern on the part of the Indiana State Department of Health, the facility took immediate action which included every 30 minute documented checks for this resident's whereabouts. These checks were in place until August 25, 2011 when Resident C's Chain of Supervision plan was implemented. An updated Elopement Risk Assessment was completed for Resident C and determined the resident to be at risk for elopement. Given the previous elopement and these findings, we communicated with the resident, her family and physician the need to re-apply a wanderguard bracelet for safety. All parties were in agreement. Daily wellness visits with Resident C will be completed for a period of two weeks to ensure Resident C's psychosocial well-being is maintained. If there are no observed psychosocial concerns, weekly wellness visits will be completed for a minimum of two additional weeks. If there then appears to be no observable psycho-social concerns, routine	

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	on 8/22/11 at 11:05 a.m. The resident's diagnoses included, but were not limited to, depression, dementia, and senile organic psychotic condition. The resident was admitted to the facility on 6/22/09. A nursing note, dated 7/12/11 at 11:30 a.m., indicated the resident had increased confusion and went into another resident's room, she was soaking wet and yelling out at this resident. The resident was redirected to go to her room and the nurse would come and help her. At 12:00 p.m., the resident was changed and remained up. The resident was reassured that staff were there to take care of her. She wanted her roommate to change her clothes. The nurse informed her staff was here for that and the roommate could not help her. A nursing note, dated 7/24/11 at 2:50 p.m., indicated the nurse was "notified that res (resident) was outside of facility off of property by herself. This writer went to get res (resident). Res (resident) a/o (alert/oriented), skin w/d (warm/dry)." The resident's vital signs were temperature 98, pulse 78, respirations 20, and blood pressure 126/60. There was no acute distress noted. At 3:15 p.m., the resident's skin check was completed with no bruising noted. The resident indicated she was in no pain. At 3:17 p.m., the physician was notified. At 3:20 p.m., the		Social Service visits will resume on an as needed basis. The results of the visits will be documented in the Social Service progress notes. The facility developed a Chain of Supervision policy and procedure to ensure appropriate supervision of residents with orders for Wanderguard protection (See attached). Staff training and in-service education was provided regarding the Chain of Supervision policy and procedure to ensure the necessary supervision and that resident safety is maintained while off of the nursing unit. The Chain of Supervision policy and procedure requires that prior to Resident C leaving the nursing unit, she be accompanied by family or a staff member. The plan requires that the resident be signed off the unit with the current date and time as well as with a notation of the expected time of her return. The individual who signs the resident out will assume responsibility for her supervision from the assigned nurse on the nursing unit and the assigned nurse will co-sign to indicate her awareness of the resident's whereabouts. The individual who has signed the resident off the unit shall be responsible for ensuring direct supervision of the resident for duration of time that she is off the unit. Upon the residents return to the unit, it will be necessary for both the person returning the	

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	resident's family was notified. At (no time indicated) a new order was received for a wanderguard. At 3:30 p.m., the wanderguard was applied to the resident's wrist and wheelchair as ordered. At 6:00 p.m., the resident had dinner in her room. At 6:10 p.m., the resident's family was visiting. At 7:00 p.m., the resident removed her wanderguard from her wrist. The resident was in her room in her wheelchair watching television. A nursing note, dated 7/25/11 at 9:00 a.m., indicated, the wanderguard remains to wheelchair. "Res (resident) states she is going to the Dollar Store next time its (sic) closer. Res (Resident) informed she is not to leave facility without staff or family." At 12:15 p.m., the resident was given her lunch tray by a CNA. The resident was in her wheelchair and set up to eat prior to CNA leaving the room. At 12:45 p.m., the resident was at the nurse's station in her wheelchair stating she did not have lunch and that her lunch was in the bathroom. The CNA indicated the resident was set by her bed and window and the resident moved the tray. The resident was ordered another lunch tray. A nursing note, dated 7/26/11 at 6:30 a.m., indicated, the resident was in her wheelchair in room, alert, verbally responsive, skin was warm and dry. She		resident to the unit and the assigned nurse to document the time of her return and sign that the nurse again resumes the responsibility for the resident's supervision. As of August 25, 2011, all of our staff have been formally in-serviced with the exception of vacationing staff, or those on a leave of absence. Staff on vacation or leave of absence have been advised they may not return to duty until they are in-serviced on the Chain of Supervision policy and procedure. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? As of August 24, 2011, all facility residents were re-assessed for risk of elopement through the use of our Elopement Risk Assessment Tool (see attached). Multi-disciplinary discussions were completed for the individuals who were identified as having risk for elopement. The family and physician of newly identified residents were contacted and necessary interventions were discussed and implemented for each individual resident effective August 25, 2011. For those residents identified as having a risk for elopement warranting the use of Wanderguard protection, a Chain of Supervision plan (as detailed above) was engaged. 3. What measures will be put into	

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	was informed to stay on the unit for meals. The resident verbalized understanding. At 7:30 a.m., the resident was up in her wheelchair attempting to go down to the main dining room for breakfast. Shed stated to writer, "I can do as I please and do you really think that I don't know what I'm doing, I know exactly what I'm doing. I'll leave when I want to leave and (Roommate's name) is staying upstairs (sic) with me." It was explained to the resident why she was not able to go downstairs. Resident calmed down and stated, "Oh whatever and said alright." A nursing note, dated 7/27/11 at 3:00 p.m., indicated the resident's wanderguard to person was discontinued due to resident removal. At 11:30 a.m., the wanderguard to the resident's wheelchair was in place. A nursing note, dated 7/28/11 at 3:10 p.m. indicated, the resident was at the nurse's station wanting to leave the facility to go to the store. The resident was redirected by staff and Administrator was made aware. At 3:20 p.m., activities will take the resident out tomorrow. A nursing note, dated 8/7/11 at 4:30 p.m., indicated the resident said "she was going to leave (sic) facility when she went to activity. The writer spoke with res		place or what systemic changes will be made to ensure that the deficient practice does not recur? The measures which were put into place to ensure that this type of occurrence does not recur involve several steps including the review and revision of facility Elopement Risk Assessment policy and procedure. All facility Social Service staff were in-serviced regarding the revisions (see attached). The facility is committed to meeting on a weekly basis for a minimum of 12 weeks and monthly thereafter (if deemed appropriate) to review and discuss all residents identified as having a risk for elopement and warrant the use of Wanderguard protection. During these meetings, the Chain of Supervision documentation will be reviewed to ensure proper completion and accuracy. Additionally, during these meetings, a review of care planning and interventions which are in place will be reviewed and discussed to ensure the effectiveness of the care plan in place. The facility posted signage at all ground floor exits urging visitors to take caution when entering and exiting the facility to ensure that unaccompanied residents do not exit with them and requesting that if such observation be made, the visitor immediately report to a staff member. The facility has added, as a part of our admission	

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	(resident) and informed her that she could not leave the facility without family or staff. Res (resident) got angry and went back to her room." A nursing note, dated 8/15/11 at 7:45 a.m., indicated the resident was upset this morning and took her breakfast tray and put it on the floor in the middle of the hallway. At 7:50 a.m., the nurse spoke to the resident and had her pick up the tray out of the hallway. The resident picked the tray up and handed it to the nurse. A nursing note, dated 8/18/11 at 2:30 p.m., indicated the resident's wanderguard was discontinued and noted by social service. The resident's family was informed. At 2:40 p.m., MDT (Multidisciplinary Team) discussion today regarding wanderguard. The resident and family requested wanderguard be removed. The resident stated, "She will not leave the facility unattended, states she would like to go to dining room for meals and wants to attend activities. MDT feels that wanderguard should be removed at this time. Resident education done at this time. A Psychiatry note, dated 7/13/11, indicated "I reviewed the nursing notes over the last month and no sleeping problems are reported. The resident		process, a notice to all new families to be cautious when entering and exiting the facility to ensure that unaccompanied residents do not exit with them and informing them to immediately report to staff any such observations. The facility will require, prior to the discontinuation of any Wanderguard protection, that a multi-disciplinary team meeting be completed including the resident/family and physician to discuss the appropriateness for removal, discussion of care plan development and the initiation of appropriate alternate interventions (where applicable). An updated Elopement Risk Assessment shall be completed and would reflect whatever change has occurred prompting the removal of the Wanderguard protection. Documentation of the rationale supporting the removal along with notation of the discussion occurring in the multi-disciplinary team meeting will be retained in the resident's medical record (see attached). The facility has included our Chain of Supervision policy and procedure as a topic in General Orientation which is presented to all newly hired staff. The facility is committed to conducting semi-annual in-servicing to all staff regarding facility elopement and the Chain of Supervision policy and procedure. The facility has	

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	urinated on self and per nursing report was observed using foul language because her roommate wouldn't help her change her clothing. I continue charting on her behaviors. She is not on the prn (as needed) Seroquel (anti-psychotic) stated earlier this year for behavioral issues." Addendum: The activity staff reported the resident was having memory problems, not able to play BINGO as before. She expects her roommate to help her and becomes angry. Resident to have urine checked and if no infection restart prn Seroquel." A Psychiatry note, dated 8/11/11, indicated, "Pt (patient) seated in room. Discussed with her the incident when she left facility to go to Target. She said she didn't know she couldn't go stating 'I used to go to Target and the Dollar Store with my mother.' She said '5 minutes more (sic) they would have never known.' She stated 'I told them I would not do it again. They are being childish about it. It makes me want to do something else.' I explained she must now be restricted as a result of her own action. She was not accepting of this. She did laugh about it when I joked about it in order to lighten up the moment. She brought up her mother as if she were alive. Her memory was impaired. She now has a wanderguard on her wheelchair. She		engaged our Wanderguard representative in assisting with the assessment and evaluation of options to further secure all facility ground floor entrances and exits with additional Wanderguard protection. To clarify, all exits on the ground floor are currently key pad locked and require the entry of a posted six (6) digit code to open the doors.4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Effective August 24, 2011, facility completed a review of every resident's chart and has verified the presence of an updated Elopement Risk Assessment and to ensure compliance with our policy on Elopement Risk Assessment. A Quality Assurance Indicator has been created to review a random sample of 20 residents per floor per month (yielding 100 audits per quarter) to assess for the presence of a current Elopement Risk Assessment, and to evaluate the presence of and appropriateness of interventions and care planning based upon the findings of the Elopement Risk Assessment. The Director of Social Service will be responsible for completing this audit and will report findings to the Quality Assurance Committee on a quarterly basis for a minimum of one year. 5. By what date will the systemic changes be	

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	reportedly cut the one off her arm." A quarterly Minimum Data Set Assessment, dated 7/21/11, indicated she was understood and she understands. She scored an eleven out of fifteen on the BIMS (Brief Interview for Mental Status) which indicated she was moderately impaired cognitively. The resident missed the correct year by one year, she was accurate to the month within five days, and she was able to recall one of the three words given at the beginning of the assessment with no cueing, she needed cueing for the second word, and could not recall the third word. A Mini-Mental State Examination (MMSE), dated 7/25/11, indicated a score of 18 out of 30 which would indicate the resident had moderate cognitive impairment. She answered correctly two of the following: year, season, date, day, and month. She answered correctly two of the following: state, country, town or city, hospital, and floor. She scored a two out of five when asked to spell the word "WORLD" backwards. When given three items to recall she could only recall one of the items. She could not copy a figure of intersecting pentagons. The resident's plan of care card indicated the resident was to have a wanderguard on		completed? August 25, 2011	

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	her wheelchair. An Elopement Risk Assessment, dated 6/22/09, indicated this was an initial assessment and the resident was at risk and a wanderguard was in place. There were no other Elopement Risk Assessments in the resident's record. A care plan, initiated on 7/24/11, indicated a problem of exiting the facility alone. The approaches included, but were not limited to, reminding the resident it was dangerous to exit the building alone, wanderguard on bottom of wheelchair due to resident removing the wanderguard from her wrist, check wanderguard placement, and notify physician of any new orders. A social service note, dated 7/20/11, indicated the resident was alert and oriented times two with confusion. There had been no behaviors present over the last seven days. The resident was seen by the psychologist on 7/13/11 and received a new order for Seroquel (anti-psychotic) as needed due to agitation. A social service note, dated 7/25/11, indicated the resident was noted outside the facility and off property without assistance. Nursing went to get the			

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	resident and returned her to the facility with no injury. The resident indicated she wanted to go shopping and later indicated she wanted to go for a walk and was tired of being inside. A new order was received for a wanderguard. The resident later removed the wanderguard to wrist and a wanderguard to wheelchair was applied. Nursing has discussed situation and safety concerns with the resident and she stated she will leave when she wants to. In morning meeting concerns were discussed and limiting resident's activity throughout the facility until resident safety can be better assessed. Social Service suggested a family meeting and family wanted to hold off at this time. The family was in agreement with facility attempts to keep resident safe with wanderguard, and limiting activities. Family indicated they visited yesterday and discussed concerns with the resident. The family indicated they will attempt to take the resident out on pass with family monthly as weather permits. Social service met with resident and discussed concerns. There resident had some confusion and noted difficulty with word finding. A social service note, dated 7/26/11, indicated the resident continues to exhibit periods of confusion and resident having difficulty with word finding and becomes			

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	frustrated in conversation at times. A new order was received to start Namenda (used to treat moderate to severe dementia). A social service note, dated 8/16/11, indicated social service was informed by nursing the resident was upset and requesting wanderguard be removed. Resident had been refusing meals at times. The wanderguard placement was discussed with MDT and family. The family was informed of risks of removing wanderguard but explained facility desire to maintain resident's independence and dignity. The concerns of the resident refusing meals and the concern of the wanderguard having a negative affect on the resident were discussed. The resident indicated she will not leave the facility again unassisted and stated to social service today she wishes she would not have left. The family feels the resident will not attempt to leave the facility again and was remorseful about the situation. Family would like the wanderguard removed. A social service note, dated 8/18/11, indicated MDT and Psychiatrist discussed with social service the removal of the wanderguard. Resident and family want the wanderguard removed. After further discussion, MDT feels that wanderguard should be removed at this time. The			

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	resident was educated on safety of not leaving the building unattended. The resident agrees and understands. Review of a reportable incident on 8/22/11 at 2:00 p.m., indicated on July 24, 2011 at 1:58 p.m., staff was made aware by another family member that Resident #C was observed at the adjacent shopping center. In viewing the video footage the resident exited the building through the patio in her wheelchair at 1:58 p.m. The resident crossed the parking lot to the shopping center sidewalk and proceeded to the far end of the strip mall. At 2:39 p.m., staff followed and the resident was returned to the facility without injury at 2:49 p.m. A Memo to the Indiana State Department of Health, dated 7/28/11, indicated "To recount the circumstance, staff was made aware by her roommate's family that (Resident #C's name) was observed entering the adjacent shopping center. In reviewing the video footage, (Resident #C's name) exited the building through the patio doors in her wheelchair at approximately 1:58 p.m., with the assistance of another resident's spouse. (Resident #C's name) proceeded in her wheelchair across the parking lot up onto the sidewalk and to the store. At 2:39 p.m., (Resident #C's name) nurse exited			

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	the same patio doors and returned with (Resident #C's name) at 2:49 p.m. (Resident #C's name), upon her return was in good spirits and without injury. The facility applied a wanderguard to (Resident #C's name) and her family and physician were made aware of the situation. In speaking with (Resident #C's name) about the incident she states she was upset because she and her roommate had plans to attend an activity together and when her roommate's family came in, she (the roommate) left to go to the store without her. The facility has requested that (Resident #C's name) not leave the unit for a period of time unless supervised by family or staff. Activity staff has agreed to take (Resident #C's name) shopping on a monthly basis and family is willing to do the same. The individual that assisted (Resident #C's name) in exiting the facility unattended has been educated on the risks of doing so and has verbalized understanding. The facility is committed to providing a safe environment for all our residents without compromising their quality of life. We will observe (Resident #C's name) for the next two weeks and			

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	evaluate her ability to safely leave the unit unattended as she has expressed a desire for independence but sometimes lack good decision making skills." The Elopement Risk Assessment Policy was provided by the Administrator on 8/22/11 at 2:40 p.m. The Social Service Department was responsible for the procedure. The purpose: "To appropriately identify those at risk for elopement." The procedure included, but was not limited to, the following: "1.0 All new admissions will be assessed by Social Service during the completion of the Social History." "2.0 All other residents will be assessed by Social Service regardless of past "no" risk scores when changes in cognitive or behavioral status or when a new diagnosis of dementia is noted. 3.0 Social Service will generate, monitor, and update care plans detailing need for elopement response system. 4.0 All residents will be assessed annually." Interview with LPN #1 on 8/22/11 during the initial tour at 10:10 a.m., indicated she was very scared when she found out Resident #C had left the facility. She was the nurse who went to get the resident and returned her to the facility. She further indicated the resident thought the situation was funny and did not seem to			

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see the danger she was in at the time. The resident had informed the LPN that if she had five more minutes she would have been back and no one would have known she was gone.

Interview with Social Service #1 on 8/22/11 at 12:00 p.m., indicated the most recent Elopement Risk Assessment for Resident #C was 6/22/09. She further indicated she was the staff member who would have completed the assessments and there were no other assessments.

Interview with the Administrator on 8/22/11 at 12:15 p.m., indicated the ground floor doors do not have a wanderguard alarm. The resident was not kept from the main dining room due to the wanderguard it was due to the staff monitoring the resident's behavior and her indicating she was still going to leave. It was then indicated with her stating she was going to leave and the doors not being activated by the wanderguard system it was felt in the best interest of the resident to keep her on the unit to monitor her behavior.

Interview with the Director of Nursing and Administrator on 8/22/11 at 2:30 p.m., indicated she thought the resident's wanderguard from 6/22/09 was discontinued in January 2010. It was

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	indicated the resident left the facility because she was angry her roommate would not be in the facility for the activity they had planned to do together and her roommate was going out with her family. It was further indicated the roommate's family will at times take Resident #C out with them when they go out. It was then indicated Resident #C had come along way from when she first came to the facility with her behaviors. Resident #C was also very territorial. It was also indicated when the resident would get on the elevator and her wanderguard would sound she would say, "That's me." Interview with the Assistant Administrator on 8/22/11 at 3:15 p.m., indicated she was not sure if or what interventions were put into place for Resident #C when her wanderguards where discontinued. Interview with the current Second Floor Unit Manager, the new Second Floor Unit Manager, Social Service #1, Administrator, and Assistant Administrator on 8/22/11 at 3:45 p.m., indicated the resident was a focused resident and she was to have periodical and interval checks being completed after her wanderguard was discontinued. It was further indicated that this meant checking on the resident during the day and multiple times at night. The resident was			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155131	A. BUILDING 00 B. WING	08/24/2011

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	in activities all day so the checking was less frequent. The facility did not indicate who would do the checking on the resident or the frequency of the checks. It was also indicated the resident was having behaviors and not eating due to the wanderguards and being monitored on the unit. It was also indicated the resident not only took off her wanderguard, but was also trying to take the wanderguard off of her wheelchair. It was thought that in the best interest of the resident and to give the resident independence the wanderguard should be discontinue. There were no other interventions indicated after the wanderguard was discontinued. It was then stressed that the resident wanted her independence and did not like staff being with her all of the time. Interview with the Activity Director on 8/23/11 at 9:45 a.m., indicated the resident had been taken to the store. She did not know exactly when the outing took place and activity notes are done monthly so they would not be in the chart yet. She further indicated the resident was taken out of the facility by staff. This Federal tag relates to complaint IN00094249. 3.1-45(a)(2)			

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